If you need assistance or have questions regarding your referral please contact central admissions at (716) 831-1800

PLEASE READ BEFORE COMPLETING APPLICATION

Thank you for your referral to the Terrace House Stabilization and/or Horizon Village Campus programs. To ensure the most efficient and accurate processing of your patients referral, **please have a counselor or case manager complete the following application in its entirety**. Please also send with your application:

- HIPAA compliant release between your agency and Horizon Health Services
- Most recent bio-psych-social assessment within the past 6 months
- Completed medical examination
- Results of toxicology screenings, blood labs and PPD results
- LOCADTR
- Complete medication list
- COVID-19 vaccination card

All applications must be faxed to 716-418-8423 to ensure receipt & timely processing

Program you are referring to:

Terrace House Crisis Stabilization _____

Horizon Village Residential Campus _____(Program to be determined upon review)

Referring Agency: _____

Patients Current Level of Care:_____

Person(s) to Contact: _____

Email: _____

Phone: _____ Fax:_____

Patient Name:_____

Social Security Number_____ DOB:_____

Birth Sex: _____ Identified Gender:_____Preferred Pronouns:_____

(Essential Patient Demographics Continued…)

Patient Address: _____

City: _____State:_____ ZIP:_____

Phone:_____ Is this: Mobile Home/landline

Current or ever have CPS involvement? **YES** **NO**

Legal Marital Status: _____

Military Experience? _____Branch:_____Seen Combat? _____

First Responder? _____ If yes, what response type:_____

Financial Information

Your patient may unknowingly incur personal responsibility for out of pocket costs if this information is inaccurate.

Primary Insurance Name:_____ Insurance ID:_____

Secondary Insurance Name: _____Insurance ID:_____

Does patient have **any** resources or assets such as, but not limited to, property ownership, bank accounts, income from wages, SSD/I, pension, 401k, alimony, child support, unemployment, marital income or settlements?

YES **NO**

If YES, please list source and value amount below:

_____

_____

Has the patient ever used any substances IV? YES NO

Substance Use History:

Substance	Frequency	Amount	Route	Date of last Use

Substance Use Treatment History: (Including hospitalizations and outpatient)

Name of Program	Level of Care	Discharge Status	Dates Attended

Mental Health Information: (Including hospitalizations and outpatient and any diagnoses)

Name of Program	Level of Care	Discharge Status	Dates Attended

Mental health diagnosis, symptoms or concerns:_____

_____

_____

History of lethality including prior attempts, past or present ideations, or self-injurious behavior:

_____

_____

Any history or thoughts, plans or attempts to harm others?_____

_____

Important psychosocial and contextual factors for patients mental health history: _____

_____

_____

Has the patient ever acted out violently or ever assaulted others?_____

_____

Medical Information:

Please list any current physical health concerns, allergies, diagnoses, conditions and surgeries:

_____

_____

_____

Name of primary care physician:_____

History of seizures? YES NO Explain:_____

Is patient pregnant? YES NO Due Date:_____ OBGYN:_____

Is the patient postpartum in the past 12 months? YES NO Delivery Date:_____

COVID-19 Screening

In the past 10 days have you been exhibiting any signs and symptoms of respiratory illness (fever, subjective or objective, i.e., T>/=100.0F) sore throat, cough, shortness of breath?

YES NO

Have you received ANY COVID-19 vaccinations? YESNO (Please also send copy of card if available)

Brand:_____ Date:_____

Brand:_____ Date:_____

Booster:_____Date:_____

Current Medications: (Including Suboxone, Subutex, Methadone, Vivitrol etc.)

Medication	Dosage	Frequency	Reason	Provider

Legal Information:

Has the patient

Accidentally or intentionally set fires? YES NO

Been charged or convicted of arson? YES NO

Been charged or convicted of a sexual offense? YES NO

Been placed on any state Sex Offender Registry? YES NO

If YES, please explain: _____

_____

Does the patient have any current legal involvement, charges or concerns at this time?

_____

_____

Is/does the patient

Incarcerated? YES NO

On parole? YES NO Officer_____

On probation? YES NO Officer _____

Have any outstanding warrants? YES NO Where_____

Mandated to our treatment program? YES NO By Who_____

Additional Information

Does the patient know of any other person currently attending Terrace House or any program on Horizon Village campus? YES NO

If YES, please explain relation: _____

_____

What are the patient primary barriers to successful treatment?_____

_____

_____

What are the patient primary motivations to participate in treatment?_____

_____

_____

I attest that all information contained in this application and referral is accurate to the best of my knowledge and understand any discrepancies or inaccurate answers can affect my placement and/or out of pocket cost within Horizon Village Inc programs.

Patient Signature: _____

Date: _____
(If patient is unable to sign, please confirm referral has been discussed and reviewed with them)